

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 36

## CERTIFICATE OF DEATH

09417

Reg. Dist. No. 351

1. PLACE OF DEATH: *Waukesha*  
 County: *Waukesha*  
 City or town: *Waukesha* (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *34 years*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: *Maryland* County: *Waukesha*  
 City or town: *Waukesha* (If outside city or town limits, write RURAL and give nearest town)  
 Street No.: *70* (If rnum, give LOCATION)

3. (a) FULL NAME  
*Richard P. Reday*

4. Sex: *Male* 5. Color or race: *White* 6. (a) Single, married, widowed, or divorced: *Married*  
 6. (b) Name of husband or wife: *Lillie Reday*

7. Birth date of deceased (mo., day, yr.): *September 26 - 1875* 8. (c) If alive, give age: *67* years

8. AGE: Years: *69* Months: *11* Days: *18* If less than one day: .hrs. .min.

9. Birthplace: *Montgomery New Jersey* (Town, county, and state)

10. Usual occupation: *Farm*

11. Industry or business: *Our Farm*

FATHER: 12. Name: *Isiah R. Reday*

MOTHER: 13. Birthplace: *New Jersey*

14. Maiden name: *Anna F. Jobulus*

15. Birthplace: *New Jersey*

16. Informant: *Mrs. Garland Taylor*

Address: *Waukesha, WI*

Burial: *Burial* Date thereof: *Sept. 16/43* (month) (day) (year)

Cemetery or crematory: *Spring Hill*

Location: *Waukesha, WI*

18. Funeral director: *Hearne & Dennis*

Address: *Spring Hill, WI*

19. Date rec'd by registrar: *9/15/45* Registrar: *R. Day Smith*

3. (b) Social Security Number: *None*

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *September 14* 1943 at *8 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept. 1* 1943 to *Sept. 14* 1943 and that I last saw him alive on *Sept. 14* 1943.

Immediate cause of death: *Carbamyl Cyanide* DURATION: *1 hr*

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations: *No* Date of op.: *Sept. 16/43*

An autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury: \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE: *J. M. H. S.* M. D. or other: \_\_\_\_\_

Address: *Alley 9, Md.* Date signed: *9/15/45*



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9<sup>th</sup>

09418

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County

Worcester

City or town

Berlin R. I. D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 months

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

## 3. (a) FULL NAME

Bronie May Chesser.

4. Sex

Female white married.

5. Color or race

6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife

Warren L Chesser.

7. Birth date of deceased (mo., day, yr.)

July 6, 1897.

8. (c) If alive, give age 57 years

8. AGE:

Years Months Days If less than one day  
48 2 19 hrs. min.

9. Birthplace

Whitesville Md.

(Town, county, and state)

10. Usual occupation

Housewife.

11. Industry or business

Elizah Fosberg

Maryland

12. Name

Elizah Fosberg

13. Birthplace

Maryland

14. Maiden name

Bronie West

15. Birthplace

Maryland

16. Informant

Mr. Warren Fosberg

Address

Berlin Md. R. I. D.

17. Burial

Date thereof 9/28/41

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Any Cemetery

Location

near Pittsville Md.

18. Funeral director

Bronie A. Baybridge

Address

Berlin Md.

19. 9-28

(Date rec'd by registrar)

19. 45

Helen F. Hayward

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Worcester

City or town

Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1945 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 25 1945 to Sept. 25 1945

and that I last saw her alive on Sept. 24, 1945

Immediate cause of death

Myocarditis (chronic) DURATION 1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

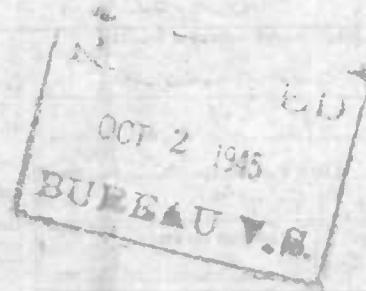
Frank P. Lewis M.D.

M. D. or other

Address Willards, Md. Date signed 9-25-45

REASON FOR TRANSMISSION STATE QUALIFICATION

NOTARIO DE MEXICO



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 931

09419

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

## 1. PLACE OF DEATH

County Worcester

City or town Pocomoke City, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Margaret E. Clarke

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 20, 1868

8. AGE:

Years

Months

Days

If less than one day

77

1

6

hrs.

min.

9. Birthplace

Pocomoke, Worcester, Md.

(Town, county, and state)

10. Usual occupation

Kept our home

11. Industry or business

William J. Clarke

MOTHER FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date reg'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Worcester

City or town Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

Street No. Second

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 26th, 1945, 10:00P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9th, 1944, to 9/26/1945,

and that I last saw her alive on September 26th, 1945,

Immediate cause of death Results of Cerebral hemorrhage. (Recurrent.) DURATION 7 Days

Primary attack - 10/9/44

Due to Arteriosclerosis. Years.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

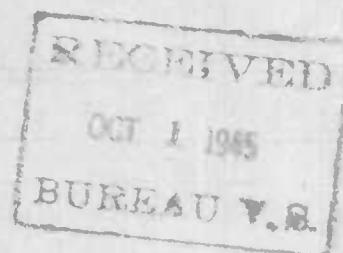
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Lee Hale M. D. or other

Address Pocomoke City, Md. Date signed 9/28/45



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

09420

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH: Worchester  
 County: Hanover Berlin  
 City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? \_\_\_\_\_  
 Hospital, Institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

3. (a) FULL NAME  
Harry F. Coffin  
 4. Sex Male Color or race White 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Maggie Coffin  
 7. Birth date of deceased (mo., day, yr.) Aug 18 1886 8. (c) If alive, give age 42 years

8. AGE: Years 59 Months 0 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Berlin  
 (Town, county, and state)

10. Usual occupation Fisherman

11. Trade or business Fish

12. Father Elisha S. Coffin

13. Birthplace Berlin Md.

14. Maiden name Ruth Anna Jarvis

15. Birthplace Berlin

16. Informant Maurice A. Coffin

Bethany Beach Del.

17. Burial Burial Date thereof Sept 11 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory 0007

Location Bethany Beach Del.

18. Funeral director M. Paschal Watson

Address Selbyville Del.

19. 9-11-45 Helen F. Hayward  
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: Maryland County: Worchester  
 City or town: Hanover Berlin (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_

2. (a) If veteran, name war: \_\_\_\_\_

3. (b) Social Security Number: \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9 1945 at 12:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19. to \_\_\_\_\_ 19.

and that I last saw him alive on \_\_\_\_\_ 19.

Immediate cause of death: Broken neck due to being hit by auto

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations: \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results: \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: Sept 9 '45

Where did injury occur? Bethany Beach Del. (City or town) (County) (State)

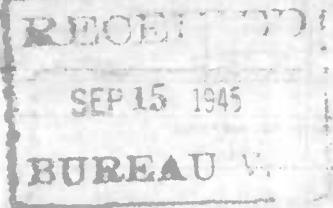
Injured at home, farm, industry, public place (where?) Highway # 213

Means of injury Struck by auto Injured at work? No

23. SIGNATURE John L. Rice D.P.M. Esq.

M. D. or other

Address: Bethany Beach Del. Date signed: Sept 9 '45



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Recd*

09421

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County *Worcester*City or town *Berlin*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *22 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Ella Amanda Dennis*

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow

## 8. (b) Name of husband or wife

*George Washington Dennis*

7. Birth date of deceased (mo., day, yr.)

*October 27, 1890*

8. (c) If alive, give age

years

## 8. AGE:

Years  
54Months  
10Days  
14If less than one day  
hrs.  
min.

## 9. Birthplace

*Maryland*

(Town, county, and state)

## 10. Death occupation

*Housewife*

## 11. Industry or business

*Charles Edward Davis*

## FATHER

12. Name

*Charles Edward Davis*

13. Birthplace

*Maryland*

## MOTHER

14. Maiden name

*Mahaley Purcell*

15. Birthplace

*Maryland*

## 16. Informant

*Mr. Raymond Dennis*

## Address

*Ocean City Md. R.I.D.*

## 17. Burial

*Burial*Date thereof  
(month) (day) (year)

## Cemetery or crematory

*Greenbushville*

## Location

*Greenbushville Va.*

## 18. Funeral director

*Dana P. Burbage*

## Address

*Berlin Md.*

## 19. 9-19-

*1945*

(Date rec'd by registrar)

*Helen F. Hayward*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Worcester*City or town *Berlin*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

*Sept. 11 - 1945*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on *Sept. 11 - 1945*

Immediate cause of death

*Carcinoma*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

## 23. SIGNATURE

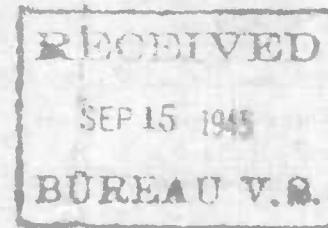
M. D. or other

Address

*Chas. R. Law*

Date signed

9-12-45



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

## CERTIFICATE OF DEATH

D. San Torino  
09422  
Reg. Dist. No. 350

## 1. PLACE OF DEATH:

County..... Worcester

City or town..... Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Maggie Lena Godfrey

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

John Henry Godfrey

6. (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

March 11, 1871

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years 74

Months 6

Days 0

If less than one day

hrs.

min.

9. Birthplace

Accomack County, VA

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Home

12. Name

Alfred Bloxom

13. Birthplace

Acco. Co. VA

14. Maiden name

Salaria Mason

15. Birthplace

Acco. Co. VA

16. Informant

John Henry Godfrey

Address

Pocomoke City, Maryland

Burial

Date thereof Sept. 13, 1941

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Metompkin

Location

Metompkin, VA

18. Funeral director

Edgar Thomas

Address

Accomac, VA

19. Date reg'd by registrar

Sept. 11, 1945

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 8th 1945 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 2nd to Sept. 7th 1945, to

and that I last saw her alive on Sept. 7th 1945.

Immediate cause of death

Cancer of stomach

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Refused operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

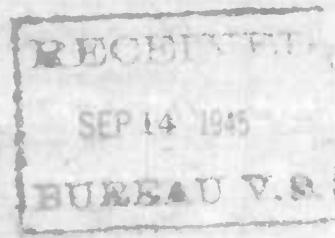
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address

Pocomoke City, MD Date signed



Miss Connie Whit  
Peggy -

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 101

09423

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

## 1. PLACE OF DEATH:

County.....

Worcester

City or town.....

Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

40 years.

Hospital, Institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution?.....

## 3. (a) FULL NAME

Sarah Holland

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Colored

Single

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age - years

Unknown

Years

Months

Days

If less than one day

hrs. min.

8. AGE:

40

(Town, county, and state)

9. Birthplace

Pocomoke, Worcester, Md.

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Housework

FATHER

12. Name.....

Unknown

13. Birthplace

Unknown

MOTHER

14. Maiden name.....

Vine Holland

15. Birthplace

Levist, Md.

16. Informant.....

Levist Holland

Address

Pocomoke, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept 16 1945

(month) (day) (year)

Cemetery or crematory

Halls Hill Baptist

Location

Rural Pocomoke

18. Funeral director.....

Margarette W. Watson

Address

Pocomoke, Md.

19. Date rec'd by registrar

Sept. 19

1945

Anne E. White

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Worcester

City or town.....

Pocomoke

If outside city or town limits, write RURAL and give nearest town

Street No.....

-

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

September 13 1945 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Sept 3rd 1945 to Sept 13th 1945

and that I last saw her alive on Sept 12th 1945

Immediate cause of death

Sept 12th 1945

Due to

Sept 12th 1945

Due to

Sept 12th 1945

Other conditions

Acute Suffocation

Lymphadenitis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

D. E. White

M. D. or other

Pocomoke City, Md. Date signed 9/15/45



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09424

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

## 1. PLACE OF DEATH:

County Worcester  
 City or town Pocomoke City Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Florence Alberta Lambertson4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Harrison Lambertson7. Birth date of deceased (mo., day, yr.) October 4, 1872 8. (c) If alive, give age 72 years8. AGE: Years 72 Months 10 Days 29 If less than one day hrs. min.9. Birthplace Stockton, Worcester, Md. (Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Charles Peter Andis13. Birthplace N. J.14. Maiden name Harriett W. Bourneville15. Birthplace Md.16. Informant Clayton F. LambertsonAddress Pocomoke City, Md.17. Burial Date thereof Sept 5, 1945(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Hall's HillLocation Pocomoke City, Md.18. Funeral director Margarette H. WatsonAddress Pocomoke City, Md.

19. Sept. 5, 1945 Date rec'd by registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Worcester  
 City or town Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No. 120 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 3, 1945 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 22, 1945 to Sept 3, 1945and that I last saw him alive on Sept 2, 1945Immediate cause of death Social Decrepit DURATION 2 daysDue to Jaundice DURATION 3 days

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

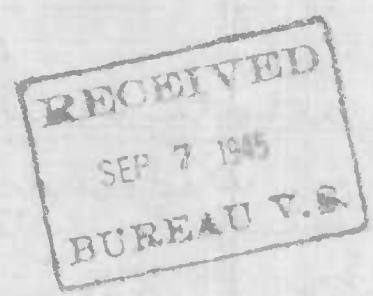
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. S. Lichten M. D. or otherAddress Queen Anne Church Date signed Sept 5, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

## CERTIFICATE OF DEATH

09425

351

Reg. Dist. No.....

1. PLACE OF DEATH: *Waucoaster*  
 County .....  
 City or town .....*Snow Hill*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *30 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State .....*Maryland* County .....*Waucoaster*  
 City or town .....*Snow Hill*  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
(If rural, give LOCATION) *70*

2.(a) If veteran, name war.

## 3. (a) FULL NAME

*Elliott W. Marshall*

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*

6.(b) Name of husband or wife *Anna Louise Marshall*

7. Birth date of deceased (mo., day, yr.) *April 19 - 1890* 6.(c) If alive, give age *51* years

8. AGE: Years *55* Months *5* Days *8* If less than one day  
 hrs. .... min. ....

9. Birthplace *Alabama* Virginia  
(Town, county, and state)

10. Usual occupation *U.S. Post Master*

11. Industry or business *Snow Hill, MD*

12. Name *Henry E. Marshall*

13. Birthplace *Virginia*

14. Maiden name *Henrietta Blopay*

15. Birthplace *Virginia*

16. Informant *Maria Anna Louise Marshall*

Address *Snow Hill, MD*

17. Burial Date thereof *Sept. 30/45*  
(Burial, cremation, or removal. Which?)

Cemetery or crematory *Whaleback*

Location *Snow Hill, MD*

18. Funeral director *Hearne & Dunn*

Address *Snow Hill, MD*

19. *3/29/1945 Leroy Smith*  
(Date rec'd by registrar)

Registrar

## 3. (b) Social Security Number

*None*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *September 27 1945*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June 12 1945* to *Sept 27 1945* and that I last saw him alive on *Sept 27 1945*Immediate cause of death *Cerebral Vascular accident*Due to *Hypertensive Cardio-Vascular Disease*Due to *obstruction*Duration *7 hours*

10 yrs

Other conditions *(Include pregnancy within 8 months of death)*Major findings or operations *Date of op.*Autopsy results *Date of op.*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Date of*Where did injury occur? *(City or town) (County) (State)*

Injured at home, farm, industry, public place (where?)

Means of Injury *Injured at work?*23. SIGNATURE *Robert L. La Mar, MD*M. D. or other *Surgeon*Address *Snow Hill*Date signed *9/28/45*



PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1318

## CERTIFICATE OF DEATH

09426

Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County Worcester

City or town Berlin Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 25 years

## 3. (a) FULL NAME

alfred M. Moore

## 4. Sex

Male

## 5. Color of race

Colored

## 6. (a) Single, married, widowed, or divorced

widowed

## 8. (b) Name of husband or wife

Mary Moore

(c) If alive, give age years

1882

## 7. Birth date of deceased (mo., day, yr.)

## 8. AGE:

Years 63

Months

Days

It less than one day

hrs. min.

## B. Birthplace

Delaware

(Town, county, and state)

## 10. Usual occupation

Day Labourer

## 11. Industry or business

## FATHER

Henry Moore

Md.

## 12. Name

## MOTHER

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. Burial

## (Burial, cremation, or removal. Which?)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19. Date rec'd by registrar

## Date thereof

Sept. 20, 1945  
(month) (day) (year)Long's  
Subdivision, Del.

Margaretha S. Watson

Econome City, Md.

Helen F. Hayward

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Worcester

City or town Berlin Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Sept. 18 1945 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..., to 19...

and that I last saw h. alive on 19...

## Immediate cause of death

Chronic Bright's

DURATION

Due to

Due to

## Other conditions

Chr. myocarditis

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

injured at work?

## 23. SIGNATURE

M. D. or other

Address

Berlin Md. Date signed 9-19-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 407

## CERTIFICATE OF DEATH

69427

351

Reg. Dlat. No.....

## 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charlie Parker

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Balck

Married

6. (b) Name of husband or wife

Mary Parker

7. Birth date of deceased (mo., day, yr.)

July 7 - 1975

66 years

8. AGE:

Years

Month

Days

If less than one day

10

2

13

hrs.

min.

9. Birthplace

Baltimore

(Town, county, and state)

Maryland

10. Usual occupation

Pianist

11. Industry or business

Stetus Dairies

FATHER

12. Name

Stephus Dairies

MOTHER

13. Birthplace

Maryland

14. Maiden name

Ethel Gable

15. Birthplace

Maryland

16. Informant

Mrs. Mary Parker

Address

Baltimore, MD

17. Burial

Rural #1

(Burial, cremation, or removal. Which?)

Date thereof: Sept. 23/45  
(month) (day) (year)

Cemetery or crematory

Locust Ridge

Location

Baltimore, MD

18. Funeral director

Herman &amp; Sons

Address

Snow Hill, MD

19. Date rec'd by registrar

9/22/45

(Date rec'd by registrar)

Reloy Smith

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

September 20 1945 at 4:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 19, 1945, to Sept. 18, 1945

and that I last saw h. m. alive on

Immediate cause of death

Convulsions of head  
of abdomen

DURATION

6 weeks

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

no

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John Parker his

Address

Salisbury Md

M. D. or other

Date signed 9/21/45



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

09428

Reg. Dist. No.

355-

## 1. PLACE OF DEATH:

County.....*Worcester*  
 City or town.....*Berlin R. I. D.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Carol Wesley Burnell*

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) .....*Sept. 6, 1945*

8. (c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day 11 hrs. min.
---------------	--------	------	--------------------------------------

9. Birthplace.....*Berlin Md R. I. D.*

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER	12. Name..... <i>William D. Penwell</i>
MOTHER	13. Birthplace..... <i>Maryland</i>

14. Maiden name..... <i>Effie Prout</i>
15. Birthplace..... <i>England</i>

16. Informant.....*William D. Penwell*Address.....*Berlin Md R. I. D.*17. Burial.....*Burial* Date thereof.....*9/8/45*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....*Penwells Cemetery*Location.....*Berlin, Md R. I. D.*18. Funeral director.....*Doris A. Burroughs*Address.....*Berlin Md*19. 9-8 Date rec'd by registrar.....*19 45*

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Worcester*

City or town.....*Berlin P. O.*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Sept. 7 1945* at.....*8 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Did not see body* to.....*19*and that I last saw h..... alive on.....*19*Immediate cause of death.....*Emphysema -**About seven months -*

Due to.....

Due to.....*Date I check visited by  
County Health Nurse -*

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

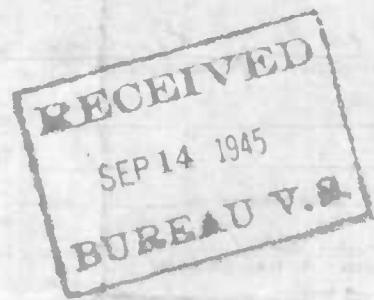
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE *Rt Johnson M.D. Deputy State Health Officer* M. D. or otherAddress.....*Primer Avenue, Md*Date signed *Sept. 7 1945*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 202

09429

## CERTIFICATE OF DEATH

Reg. Dist. No.

355

## 1. PLACE OF DEATH: Worcester

County.....

City or town..... Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, institution, or street address where death occurred:..... no

How long in hospital or institution?..... no

## 3. (a) FULL NAME

Wm J. Purcell

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male wags married -widower

6.(b) Name of husband or wife

Margaret Purcell

7. Birth date of

deceased (mo., day, yr.) Dec 24 about 1872

8. (c) If alive, give age ..... years

8. AGE: Years Months Days It less than one day  
72 8 13 hrs. min.

9. Birthplace..... Maryland

(Town, county, and state)

10. Usual occupation..... Laborer.

11. Industry or business..... Ice delivery

12. Name..... Charles Purcell

13. Birthplace..... Berlin MD

14. Maiden name..... Anna Henry

15. Birthplace..... Berlin MD

16. Informant..... Roxie Purcell Jones

Address..... Berlin, Md

17. Burial..... Sept 12, 1945

(Burial, cremation, or removal. Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory..... Evergreen

Location..... Berlin, Md

18. Funeral director..... James P. Stewart

Address..... Salisbury, Md

19. 9-12

(Date rec'd by registrar) 1945 Nelson G. Maynard

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Worcester

City or town..... Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No. 240 Bay St (If rural, give LOCATION)

2.(a) If veteran, name war..... no

## 3. (b) Social Security Number

Entire

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 6

1945 at 10:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on.....

## Immediate cause of death.....

Myocardial degeneration  
of heart

DURATION

Due to.....

Due to.....

## Other conditions.....

(Include pregnancy within 8 months of death)

## Major findings of operations.....

Date of op.....

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of Injury.....

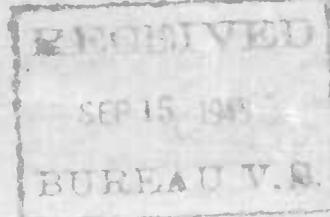
Injured at work?

## 23. SIGNATURE

John L. Reilly, Dep. Dir. Examin.

M. D. or other

Address..... Brown Hill, Md Date signed 9/6/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-2

09430

## CERTIFICATE OF DEATH

Reg. Dist. No. 351

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Stanbury S. Ritchie

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife.....

Josephine O. Ritchie

7. Birth date of deceased (mo., day, yr.)

June 15 1858

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

77

3

6

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Salisbury, Womeric

MD

10. Usual occupation.....

Farmer

11. Industry or business

12. Name.....

George W. Ritchie

13. Birthplace

Maryland

14. Maiden name.....

Mack Bell

15. Birthplace.....

Maryland

16. Informant.....

Mrs. Sadie P. Mumford

Address.....

Shaytay, MD

17. Burial.....

Bates

Date thereof.....  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)  
Sept. 23 1945

Cemetery or cremator.....

Location.....

Snow Hill, MD

18. Funeral director.....

Carne &amp; Donald

Address.....

Snow Hill, MD

19. Date rec'd by registrar.....

1945

Lester Smith

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

Snow Hill (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION) 70

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

701

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

September 21 1945 at 7 A.M.  
Aug 21 1945 to Sept 21 1945  
and that I last saw him alive on Sept 17 1945

Immediate cause of death.....

Aute Pulmonary Edema

1 day

Due to..... Congestive Heart Failure &amp; senility

2 mos

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Robert L. La Mar, M.D.

M. D. or other

Address.....

Snow Hill

8-12-45

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctage is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

## CERTIFICATE OF DEATH

1943

Reg. Dist. No. 350

## 1. PLACE OF DEATH:

County..... **Worcester**  
 City or town..... **RURAL, Pocomoke City**

(If outside city or town limits, write RURAL and give nearest town)

**57 years**How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

**Leah White**

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

**Female    Colored    Widowed**6. (b) Name of husband or wife..... **Eben White**7. Birth date of deceased (mo., day, yr.) **Mo & da Unknown 1888**8. AGE:      Years      Months      Days      If less than one day  
**57      ?      ?      hrs.      min.**9. Birthplace..... **RURAL, Pocomoke-Worcester-Md.**  
 (Town, county, and state)10. Usual occupation..... **Housewife**

## 11. Industry or business

12. Name..... **Smith Bacon**13. Birthplace..... **RURAL Pocomoke City, Md.**14. Maiden name..... **Hattie Teagle**15. Birthplace..... **RURAL, Pocomoke City, Md.**16. Informant..... **Sarah Matthews**Address..... **Pocomoke City, Md. RFD #2**17. Burial..... **Burial** Date thereof **Sept. 11, 1945**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... **St. James Cemetery**Location..... **Pocomoke City, Md. RFD #2**18. Funeral director..... **H. Harvey Bradshaw**Address..... **Pocomoke City, Md.**19. Date rec'd by registrar..... **Sept. 11, 1945**

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County..... **Worcester**City or town..... **RURAL, Pocomoke City**  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **September 7 1945** at **12:30 A.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**8/7/45** 19..... to **9/7/45** 19.....  
 and that I last saw her alive on **9/7/45** 19.....

Immediate cause of death.....

**Pulmonary Tuberculosis**

DURATION

**6 mo**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... **Paul Cohen M.D.**

M. D. or other

Address..... **Browell Hill** Date signed **Sept. 11, 1945**

